Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
HealthTrust LLC

Respondent Name
City of San Antonio

MFDR Tracking Number
M4-14-3258-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
June 30, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "HealthTrust received preauthorization on a total of 20 sessions of a multi-disciplinary chronic pain management program and provided those services accordingly."

Amount in Dispute: $25,980.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "In summary, dates of service August 12 through 19, 2013 are not eligible for medical dispute resolution as the provider did not request reconsideration prior to filing the medical dispute. The TPA did not receive bills for dates of service 08/20/13 through 9/19/2013. The documentation for dates of service 09/23/2013 through 09/30/13 does not justify a reimbursement for eight hours of therapy. Therefore, no additional allowance is due for any disputed date of service."

Response Submitted by: Argus, 811 S. Central Expwy, Suite 440, Richardson, TX 75080

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 12, 2013 through September 30, 2013	97799 CP, 96151	$25,980.00	$11,940.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.204 provides medical fee guideline for workers' compensation specific services.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 16 – Claim/service lacks information which is needed for adjudication
   - 193 – Original payment decision is being maintained
   - W1A – Workers compensation state fee schedule adjustment

Issues

1. Did the requestor comply with Division guidelines regarding MFDR?
2. What is the applicable rule pertaining to reimbursement?
3. Is the requestor entitled to reimbursement?

Findings

1. The carrier states, "…dates of service August 12 through 19, 2013 are not eligible for medical dispute resolution as the provider did not request reconsideration prior to filing the medical dispute." Review of the submitted documentation finds an email dated February 6, 2014 from Tony Chapman of HealthTrust, to Yvonne Rivers of Tristar Group Net which states, "Not an appropriate amount of payment based on documentation." Therefore, the carrier's position is not supported. These dates of service will be considered as part of Medical Fee Dispute.

    a. The carrier states, "The TPA did not receive bills for dates of service 08/20/13 through 9/19/2013**."** Review of the submitted documentation finds certified mail receipts showing delivery of claims to Tri Star Risk Mgmt on September 24, 2013 and September 27, 2013. The Division finds the carrier's position is not supported. Therefore, the services in dispute will be reviewed per applicable rules and fee guidelines.

    b. Review of the submitted documentation finds the requestor did submit medical documentation to support the level of services as submitted. Therefore, the services in dispute will be reviewed per applicable rules and fee guidelines.

2. 28 Texas Administrative Code §134.204(h)(1)(A) states, "The following shall be applied to Return To Work Rehabilitation Programs for billing and reimbursement of Work Conditioning/General Occupational Rehabilitation Programs, Work Hardening/Comprehensive Occupational Rehabilitation Programs, Chronic Pain Management/Interdisciplinary Pain Rehabilitation Programs, and Outpatient Medical Rehabilitation Programs. To qualify as a Division Return to Work Rehabilitation Program, a program should meet the specific program standards for the program as listed in the most recent Commission on Accreditation of Rehabilitation Facilities (CARF) Medical Rehabilitation Standards Manual, which includes active participation in recovery and return to work planning by the injured employee, employer and payor or carrier. (A) If the program is CARF accredited, modifier "CA" shall follow the appropriate program modifier as designated for the specific programs listed below. The hourly reimbursement for a CARF accredited program shall be 100 percent of the MAR. 28 Texas Administrative Code §134.204(h)(5) states, "The following shall be applied for billing and reimbursement of Chronic Pain Management/Interdisciplinary Pain Rehabilitation Programs. (A) Program shall be billed and reimbursed using CPT Code 97799 with modifier "CP" for each hour. The number of hours shall be indicated in the units column on the bill. CARF accredited Programs shall add "CA" as a second modifier. (B) Reimbursement shall be $125 per hour. Units of less than one hour shall be prorated in 15 minute increments. A single 15 minute increment may be billed and reimbursed if greater than or equal to eight minutes and less than 23 minutes." And "(5) Return To Work Rehabilitation Programs. The following shall be applied for billing and reimbursement of Work Conditioning/General Occupational Rehabilitation Programs, Work Hardening/Comprehensive Occupational Rehabilitation Programs, Chronic Pain Management/Interdisciplinary Pain Rehabilitation Programs, and Outpatient Medical Rehabilitation Programs. To qualify as a commission Return to Work Rehabilitation Program, a program should meet the "Specific Program Standards" for the program as listed in the most recent Commission on Accreditation of Rehabilitation Facilities (CARF) Medical Rehabilitation Standards Manual. Section 1 standards regarding Organizational Leadership, Management and Quality apply only to CARF accredited programs. (A) Accreditation by the CARF is recommended, but not required. (i) If the program is CARF accredited, modifier "CA" shall follow the appropriate program modifier as designated for the specific programs listed below. The hourly reimbursement for a CARF accredited program shall be 100% of the MAR. (ii) If the program is not CARF accredited, the only modifier required is the appropriate program modifier. The hourly reimbursement for a non-CARF accredited program shall be 80% of the MAR." The calculation of the Maximum Allowable Reimbursement (MAR) is found below:

Date of Service	Submitted Code	Submitted Charges	Units	MAR	Paid Amount	Amount Due
August 12, 2013	97799 CP	$1560.00	8	125 x 80% = $100 x 8 = $800.00	$300.00	$500.00
August 13, 2013	97799 CP	$1560.00	8	125 x 80% = $100 x 8 = $800.00	$300.00	$500.00
August 14, 2013	97799 CP	$1560.00	8	125 x 80% = $100 x 8 = $800.00	$300.00	$500.00
August 15, 2013	97799 CP	$1560.00	8	125 x 80% = $100 x 8 = $800.00	$300.00	$500.00

August 19, 2013	97799 CP	$1560.00	8	125 x 80% = $100 x 8 = $800.00	$300.00	$500.00
August 20, 2013	97799 CP	$1560.00	8	125 x 80% = $100 x 8 = $800.00	$0.00	$800.00
August 21, 2013	97799 CP	$1560.00	8	125 x 80% = $100 x 8 = $800.00	$0.00	$800.00
August 22, 2013	97799 CP	$1560.00	8	125 x 80% = $100 x 8 = $800.00	$0.00	$800.00
August 23, 2013	97799 CP	$1560.00	8	125 x 80% = $100 x 8 = $800.00	$0.00	$800.00
August 26, 2013	97799 CP	$1560.00	8	125 x 80% = $100 x 8 = $800.00	$0.00	$800.00
August 26, 2013	96151	$240.00	1	MAR of $31.03 at 8 units is $248.24. Per §134.203(h), reimbursement is the lesser of the MAR or the provider's usual and customary charge. The lesser amount is $240.00.	$0.00	$240.00
September 16, 2013	97799 CP	$1560.00	8	125 x 80% = $100 x 8 = $800.00	$0.00	$800.00
September 17, 2013	97799 CP	$1560.00	8	125 x 80% = $100 x 8 = $800.00	$0.00	$800.00
September 18, 2013	97799 CP	$1560.00	8	125 x 80% = $100 x 8 = $800.00	$0.00	$800.00
September 19, 2013	97799 CP	$1560.00	8	125 x 80% = $100 x 8 = $800.00	$0.00	$800.00
September 23, 2013	97799 CP	$1560.00	8	125 x 80% = $100 x 8 = $800.00	$400.00	$400.00
September 24, 2013	97799 CP	$1560.00	8	125 x 80% = $100 x 8 = $800.00	$400.00	$400.00
September 26, 2013	97799 CP	$1560.00	8	125 x 80% = $100 x 8 = $800.00	$400.00	$400.00
September 27, 2013	97799 CP	$1560.00	8	125 x 80% = $100 x 8 = $800.00	$400.00	$400.00
September 30, 2013	97799 CP	$1560.00	8	125 x 80% = $100 x 8 = $800.00	$400.00	$400.00
	Total	$31,440.00		$15,440.00	$3,500.00	$11,940.00

3. The total MAR for the services in dispute is $15,440.00. The carrier previously paid $3,500.00. The remaining balance is $11,940.00. This amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $11,940.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $11,940.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

Authorized Signature

		December 8, 2014
Signature	Medical Fee Dispute Resolution Officer	Date
		December 8, 2014
Signature	Medical Fee Dispute Resolution Manager	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.